TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Travelers Casualty Ins Co of America

MFDR Tracking Number
M4-17-0335-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
October 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 23412, allowed amount of $4,369.67 multiplied at 200%, CPT Code 23430, allowed amount of $4,369.67 multiplied at 200% x 0.5 and CPT Code 93005, allowed amount of $81.25, multiplied at 200% reimbursement should be $13,369.89. Payment was received was only $8,739.34, thus, according to these calculations; there is a pending payment in the amount of $4,109.56."

Amount in Dispute: $4,630.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider apparently contends they are entitled to reimbursement for CPT code 23430 under the secondary procedure reimbursement methodology and the ancillary codes as separate reimbursement. The Carrier has reviewed the billing edits for these procedures. CPT code 23430 is bundled with CPT code 23412 for reimbursement. Consequently, separate reimbursement is not due for this procedure. The ancillary codes are included in the primary procedure reimbursement and are not eligible for separate reimbursement."

Response Submitted by: Travelers Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2016 through April 7, 2016	Outpatient hospital services	$4,630.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because of the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 4097 – Pain per fee schedule; charge adjusted because status dictates allowance is greater than provider's charge
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - 797 – Service not paid under Medicare OPPS
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed
   - W3 – Additional payment made on appeal/reconsideration
   - 947 – Upheld no additional allowance has been recommended
   - 974 – This procedure is included in the basic allowance of another procedure

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $4,630.55 for outpatient hospital services rendered between March 31, 2016 and April 7, 2016.

   The insurance carrier reduced the disputed services with reduction codes, P12 – "Workers compensation jurisdictional fee schedule adjustment," and 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

2. The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Rank used for primary assignment	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.7989	40% non-labor related	Payment	Maximum allowable reimbursement
23412	5123	J1	371	$4,969.26	$4,969.26 x 60% = $2,981.56	$2,981.56 x 0.7989 = $2,381.97	$4,969.26 x 40% = $1,987.70	$2,381.97 + $1,987.70 = $4,369.67	$4,369.67 x 200% = $8,739.34
23430	5123	J1	374	$0.00 see below					
								Total	$8,739.34

The status indicator J1 has the following definition:

> *J1 - Hospital Part B services paid through a comprehensive APC*
>
> *Paid under OPPS; all covered Part B services on the claim are packaged with the **primary** "J1" service for the claim except service with OPPS SI=F,G,H,L and U; ambulance services; diagnostic and screening mammography, all preventive services; and certain Part B inpatient services*

Review of the submitted medical claim finds the primary procedure is code 23412 with a ranking of 371. This is the highest-ranking code. The secondary procedure of code 23430 is therefore bundled. No separate payment allowed.

The remaining services have the following classifications:

- Procedure code 80048, date of service March 31, 2016, has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 85025, date of service March 31, 2016, has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code C1713 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J7030 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J3010 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2250 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2795 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2270 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J0171 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J0690 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J1885 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2175 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2405 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2765 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J0131 has status indicator N denoting packaged codes with no separate payment.
- Procedure code A9270 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill.
- Procedure code 93005, date of service March 31, 2016, has status indicator Q1 denoting STVX-packaged codes; payment for these services are packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures reported for the same date.
- Per Medicare's National Correct Coding Initiatives found at www.cms.gov, procedure code 96374 may not be reported with the procedure code 23412 billed on this same claim. Payment for this service is included in the payment for the primary procedure.

3. The total allowable reimbursement for the services in dispute is $8,739.34. This amount less the amount previously paid by the insurance carrier of $8,739.34 leaves an amount due to the requestor of $0.00. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.